Draft Meeting Summary
Freestanding Medical Facility Work Group Meeting
Tuesday October 6, 2015
MHCC, 4160 Patterson Avenue, Baltimore, MD 21215

Work Group Member Attendees:
Carl Jean-Baptiste (substitute for Neil Moore)
Hugh Guest
John Hamper (by phone)
Robert Jepson
Dean Kaster
Brett McCone
Lisa Myers
Amy Perry
Renee Webster (by phone)
Jennifer Wilkerson

MHCC Staff Attendees:
Eileen Fleck
Paul Parker
Kathy Ruben
Ben Steffen
Suellen Wideman

Other Attendees:
Miriam Suldan
Clarence Brewton
Donna Jacobs
Jennifer Witten
Ella Aiken

Introductions

The meeting convened at approximately 10am. Eileen Fleck, Chief of Acute Care Policy and Planning thanked everyone for attending the work group meeting and explained that the goal of the meeting was to wrap up the discussion of the draft State Health Plan (SHP) chapter provided to work group members. The draft SHP chapter will then be posted for informal comment. Ms. Fleck asked everyone to introduce themselves.

Review of August Meeting Summary

Ms. Fleck then asked the work group for their feedback on the previous meetings summary. There were no recommended changes to the meeting summary. A few members noted that the meeting summary was very comprehensive. Ms. Fleck indicated that she would allow members a few more days to review the meeting summary before finalizing it. Robert

Jepson noted that while he would not propose any changes to the meeting summary, he wanted to note that the discussion of the impact standard at the first meeting did not resolve the concerns raised. Ms. Fleck said that the agenda could be changed slightly to give the work group a chance to discuss the impact Project Review Standard.

Service Area Definition

Ms. Fleck next suggested that the work group review a set of maps with the 85-percent service area for emergency department (ED) visits of the three parent hospitals for the three freestanding medical facilities (FMFs) in Maryland. She distributed a total of five maps. For the two pilot FMFs, there was a map for the parent hospital's 85-percent service area for ED visits in the fiscal year (FY) prior to establishment of the FMF. Ms. Fleck noted that the service area often covered a large area, as indicated by the circle drawn on each map that enclosed the 85% ED service area for the hospital. She also noted that the Germantown Emergency Center was located in the zip code area that accounted for the highest number of ED visits to Adventist Shady Grove Medical Center in FY 2006. In contrast, the zip code area containing the Queen Anne's Emergency Center was not within the top 80% of zip code areas for ED visitors to the University of Maryland Shore Medical Center at Easton.

Ms. Amy Perry asked Ms. Fleck for further explanation of how a hospital's 85% service area is defined. Ms. Fleck explained that it is defined as the zip code areas from which, cumulatively, the top 85% of patient visits to a hospital's ED or an FMF originate, when the zip code areas are ranked from highest to lowest based on the number of visits at the hospital's ED, including patients initially seen at the hospital's FMF who were transferred and admitted to the hospital.

Ms. Perry expressed concern about the leeway granted for choosing the location of an FMF and the potential for a hospital to take market share from other hospitals and create unnecessary, duplicative services. She noted that the purpose of Certificate of Need (CON) regulations is to reduce waste in the health care system. She proposed that a much smaller service area be defined as appropriate for the location of an FMF, especially for hospitals in urban locations. Specifically, she mentioned 15% might be considered for urban locations. Mr. Dean Kaster reminded the work group that for some hospitals in rural areas, such as the Eastern Shore, the larger service area is needed when considering the development of an FMF to improve access.

Ms. Perry also commented that in her view FMFs should only be used to address access and not crowding of EDs. Several work group members stated that even if an applicant's emergency department was over crowded, the population in the area of the proposed FMF may be better served by another hospital's ED. Mr. Jepson disagreed with removing overcrowding as a basis for establishing an FMF. It was noted that for the Germantown Emergency Center both overcrowding and access were cited as the basis for establishing an FMF, and there was a slight expansion of the emergency department at the parent hospital.. Ms. Perry suggested that it is very important to consider whether a hospital has done everything possible to reduce

unnecessary ED visits. Ms. Fleck agreed with Ms. Perry and noted that an applicant would be expected to address that question.

Ms. Fleck and Mr. Paul Parker Director of the Center for Health Care Facilities Planning and Development, noted that other CON standards such as the impact standard and the cost effectiveness standard would address some of the concerns Ms. Perry raised. Other work group members agreed that the other CON standards could be used to address concerns about duplication and the impact on other hospitals. Mr. Carl Jean-Baptiste commented that the service area should not be reduced to deal with the potential impact on other hospitals. He favored using other means. Mr. Parker also noted that if an FMF had to be located very close to the parent hospital then it might not serve to improve access to emergency care. Ms. Fleck asked work group members if they wanted to comment on the impact standard. Mr. Jepson noted that the previous discussion of the impact standard on page 14 of the meeting summary accurately captured his viewpoint. There were no other comments on the impact standard. Ms. Fleck asked whether there were specific standards that should be incorporated to give clear guidance to applicants as to the level of effort required. There were no suggestions from work group members. Ms. Fleck encouraged work group members to email additional feedback following the meeting.

State Health Plan Chapter Discussion

General Standards

Mr. Parker, described the General Standards section of the State Health Plan (SHP) chapter to the work group. He explained that these three standards are included in COMAR 10.24.10.04A, and the standards apply to all hospital projects, and only a hospital would be allowed to propose an FMF. He explained that hospitals are expected to provide information on the charges for services and to have a written policy for the provision of charity care. He also explained the third general standard regarding quality of care. He mentioned that the quality of care standard in particular should be updated, but MHCC staff concluded that it is better to reference the general standards and to update the general standards later, when the State Health Plan chapter that includes those standards is updated. Ms. Perry suggested that the quality of care standards should be updated to reflect the new waiver model for Maryland because a hospital that fails to meet expectations puts a greater burden on other hospitals to compensate for the performance of that hospital. Mr. Kaster agreed that the bar should be raised for hospitals, but it may not be appropriate to make a change in the FMF SHP chapter. Mr. Parker agreed, noting that MHCC staff wants to expediently establish the regulations for CON reviews of FMF projects, and making a change to the quality standard referenced in COMAR 10.24.10.04A(3) could slow the process considerably.

Project Review Standards

Ms. Kathleen Ruben explained two project review standards that the work group had not yet discussed, construction costs and preference in comparative reviews.

Construction Costs

Ms. Ruben explained that the standard for Construction Costs is based on the standard included in COMAR 10.24.10, the State Health Plan chapter for acute care hospital services. She then read the first part of the Project Review Standard, as shown below.

> *the proposed construction cost of the project shall be reasonable and consistent with current industry cost experience in Maryland. The projected construction and renovation costs per square foot will be compared to the most applicable benchmark cost of good quality Class A health care facility construction of hospital ED space given in the Marshall Valuation Services guide.*

Ms. Ruben then explained that the Marshall Valuation Service Guide is a complete appraisal guide for developing project costs. It is an industry standard in the U.S. that has regularly updated data including cost of labor, materials and installed components.

Ms. Ruben further explained that the draft SHP calls for the project to be updated, and adjusted for cost differential and other factors using the Marshall Valuation Service guide. Also, if the projected cost exceeds the benchmark cost, then any change in the global budget revenue or total patient revenue cap proposed by the hospital will not include the amount of the projected construction cost that exceeds the benchmarks. Ms. Ruben then asked if there were any questions or comments about the Construction Project Review Standard section.

Mr. Brett McCone commented that his understanding is that each FMF has its own separate global budget, so the wording in the construction project review standard was confusing. Instead of using the word "change" (in a global budget review), it was suggested that "impacts" be used.

Preference in Comparative Reviews

Ms. Ruben summarized the comparative review standard, and she noted each of the five factors that determine the Commission's preference. These factors include cost effectiveness, ability to reduce low acuity visits, outreach to certain types of patients, research or educational components that offer special advantages, and the ability to improve access to primary care for patients seen at the proposed FMF.

She explained that in a comparative review the Commission will evaluate how an applicant addresses the general standards and project review standards, and if a preference is given to one applicant, the chosen applicant must have demonstrated the most cost-effective way to achieve the objectives; proven its ability to reduce low acuity visits and inappropriate use of the parent hospital's ED; provide more effective outreach to minority, indigent, and underserved patients in the hospital's service area; provide research, education, or training opportunities as an integral part of the project that are designed to meet regional needs that offer advantages; and the ability to promote coordination of care with primary care providers. Ms. Ruben then asked if there were any questions or comments about this standard.

Mr. Jepson asked whether the standards pertain specifically to the proposed project or to the parent hospital. Ms. Fleck commented that the population to be served is the context of the standard. Mr. McCone commented that whether the project or parent hospital should be considered may be different for different preference standards. Mr. Jepson also asked whether an applicant would be evaluated based on retrospective review or an assessment of its prospective plans. Ms. Perry agreed that Mr. McCone and Mr. Jepson made good points. She added that it is very subjective as to what counts as an effective discharge plan, and good planning requires that social work and primary care networks be utilized. She also noted that preventative care initiatives matter too.

Ms. Jennifer Wilkerson asked for clarification on the language in the standard regarding when it would apply. The standard states that there will be a comparative review if two or more applicants have overlapping service areas or if at least one applicant obtains interested party status in opposition to a proposed FMF. Mr. Parker explained that sometimes applicants may oppose each other, but they may not always.

Mr. Jepson asked whether MHCC has to choose one of two proposed projects or whether it may approve both projects or reject both projects. He suggested that the language be clarified to address the issue.

Definitions

Ms. Fleck noted that several definitions in the draft SHP chapter, such as the definition of an FMF, had been discussed at the previous meeting. However, she explained that she wanted to discuss the definition of acuity level because the definition pertains to an applicant's demonstration of the need for an FMF. She read the following definition.

> *"Acuity Level" means a five-level emergency department triage algorithm that uses the Emergency Severity Index (ESI) developed by the Agency for Healthcare Research & Quality that provides clinically relevant stratification of patients into five groups from the most to the least urgent, with Level 1 life-threatening, Level 2emergent/high-risk, Level 3-urgent, Level 4-less urgent, and Level 5-nonurgent.*

Ms. Fleck explained that MHCC currently has data for the emergency management codes that reflect resource use. However, MHCC staff does not have access to the acuity level for ED visits. She asked for confirmation that hospitals have such information readily available for all ED visits. Work group members confirmed that it is readily available. Ms. Fleck then asked whether it was important for MHCC to have data for all hospitals in order to have greater context for evaluating applications, rather than having only the information presented by an applicant or multiple applicants. Work group members suggested that it would be sufficient to rely on the information presented by an applicant or multiple applicants. Mr. McCone noted the Maryland Hospital Association is currently reviewing data collection to consider ways to reduce the burden on hospitals. It was also noted that other stakeholders should be consulted regarding any additional data collection. Ms. Fleck agreed that other stakeholders would need to be consulted regarding additional data collection. Ms. Fleck provided the work group with the definition of

urgent care that is in the draft SHP and asked if there was a better definition. The definition states that urgent care "means the provision of medical services on a walk-in basis for primary care, acute or chronic illness, and injury." The work group consensus was that this definition was reasonable.

Limited Service Hospitals and FMFs

Mr. Parker explained that MHCC staff plans to move forward with the process of developing CON regulations for FMFs for the purposes described in the draft SHP chapter. However, MHCC also wanted to obtain feedback from the work group on the idea of using FMFs as a transition model for a hospital that is downsizing. He noted that limited service hospitals (LSHs) and FMFs are very similar in some respects. He also explained that the limited service hospital concept was established in the 1990s when the volume of discharges for hospitals was declining, and it was anticipated that some hospitals would downsize or close. However, the discharge volume for hospitals increased, and no hospital has ever become a limited service hospital. Mr. Parker asked for feedback on the idea of using FMFs as a transition model for a hospital that is downsizing. Mr. Ben Steffen, Executive Director for MHCC, agreed that the limited service hospital concept was stillborn as noted by Mr. Parker. He also explained that the law would need to be changed in order for FMFs to be used as a transition model for a hospital seeking to downsize. He emphasized that MHCC would not be sponsoring legislation regarding FMFs as a transition model for a hospital that is downsizing.

Mr. Jepson commented that it is reasonable to have LSHs replaced by FMFs. He also asked for clarification on whether there would be an exemption from CON review if an FMF is used to downsize a hospital. Mr. Parker agreed that an exemption would be appropriate. Ms. Perry commented that she would hesitate to support an exemption from CON review in those circumstances because a hospital should have to demonstrate that an FMF is needed. Another work group member, Mr. Jean-Baptiste disagreed with Ms. Perry. He explained that it is important to have an expedient process for closing or downsizing. It was noted that a hospital may close without a Certificate of Need. Suellen Wideman, an Assistant Attorney General for MHCC, explained that an exemption from CON review is still a process that requires action by the full Commission. In addition, the Commission must find that the proposal is consistent with the State Health Plan. Ms. Wilkerson commented that having a distinct process for each makes sense and having less paperwork for a hospital seeking to downsize makes sense. Mr. Kaster commented that he agreed with Ms. Wilkerson. He also noted that hospitals are under a lot of pressure with the waiver and converting to a less intensive model of care makes sense for some locations. Ms. Wilkerson added that geography is still important.

One of the work group members asked where a hospital could locate an FMF if it downsized. Ms. Wideman noted that for a hospital seeking to convert to an LSH, it must locate the LSH within the immediate area, which is defined as within five miles. Another work group member commented that five miles in western Maryland is very different than in Prince George's County. It was proposed that the approval should be for a particular site because of the opportunity for poaching, and an FMF should be located on the same site as the former hospital. Mr. Kaster commented that it is important to consider who is being served. He noted that the

Eastern Shore is very different than Baltimore City. In rural and outer suburban ommunities, it's important for a hospital to be able to relocate as a means of providing better access. Ms. Renee Webster commented that an LSH still needs to be affiliated to get provider based status from CMS, similar to an FMF.

Mr. Jepson commented that he agreed with Ms. Perry. Mr. Steffen asked Mr. Jepson if he understood that locating within five miles of the existing hospital is acceptable for an LSH. Mr. Jepson confirmed that he understood the standards for an LSH. However, the impact of a new FMF on other hospitals is a concern. Mr. Jean-Baptiste commented that an LSH and FMF should be regulated similarly. Mr. McCone asked whether recognizing differences among jurisdictions would be appropriate because five miles is very different in Montgomery County compared to Garrett County. Mr. Jepson commented that if a five mile radius is used then there should not be an exemption. Ms. Perry agreed. She stated that locating on the same site is acceptable, but any move at all, even a block, should require a CON. Mr. Jepson noted that the purpose of the option of an FMF or LSH is to have continued access to care. Mr. Kaster proposed that if the jurisdiction has a single provider then there needs to be flexibility. Mr. Jepson agreed that if there is only one hospital in a county then it can be handled differently.

Mr. Kaster commented that there are many other issues to consider that have not been discussed, such as observation beds, rate reimbursement, and the types of outpatient services allowed, if an FMF becomes a model for downsizing.

Next Steps

Ms. Fleck thanked work group members for their participation and noted that MHCC staff would post a draft for informal public comment. She noted that the work group members would be notified once a draft is posted, and everyone is welcome to submit comments. Staff would use the comments to put together a draft proposed regulation for consideration by the Commission. Ms. Fleck also explained that she would send out a draft meeting summary for review by work group members, and it would be finalized based on feedback provided by email. She noted that the work group would not meet again prior to the submission of a draft proposed regulation to the Commission. However, the work group could potentially meet again to amend regulations in the future, if there are statutory changes. Ms. Fleck gave audience members an opportunity to speak before the meeting was concluded. However, no members of the public wanted to comment. The meeting was adjourned around noon.